Julie Hanson, LCSW
Selah Healthcare Professionals
18-2 E. Dundee Rd, Suite 140
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Welcome!

You have taken a courageous step by making a counseling appointment. In doing so you are declaring that your emotional, spiritual and relational health is important to you. I am anxious to begin working with you and hope that your experience will be a positive one. I have developed the following materials to facilitate our alliance. This packet contains the following:

- Registration Form
- Insurance Checklist and Verification of Benefits
- Credit Card Authorization
- Practice Policy Statement which includes fees, cancellation and emergency information.
- HIPAA Notice of Privacy Practices
- HIPAA Notice of Privacy Practices Acknowledgement of Receipt
- Consent to Treatment

Please read these materials before our first appointment. I welcome any questions that you may have.

Sincerely,

Julie Hanson, LCSW

Julie Hanson, LCSW

REGISTRATION FORM

(please print)

Today's Date:	Primary Care Physician

PATIENT INFORMATION

Patient's Last Name First Name Middle	☐ Mr ☐ Miss ☐ Mrs ☐ Ms	**Marital Status (circle one)** Single Married Divorced Separated Widowed Other

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	**Date of Birth**	**Age**	**Sex**
			/ /	____	☐ Male ☐ Female

Street Address:	Home Phone#	Cell Phone#
City:	State:	Zip
Email:	May I leave a message on one? ☐ Email ☐ Home Phone# ☐ Cell Phone #	

Emergency Contact:	Relationship to Patient:	Phone:

Name of Parent or Guardian if patient is a minor or dependent: _____

Relationship to Client: _____ Phone: _____

Primary Concern for coming to counseling:

How were you referred to Julie Hanson, LCSW?

BILLING/INSURANCE INFORMATION

(A COPY OF YOUR INSURANCE CARD IS REQUIRED BEFORE ANY CLAIMS CAN BE FILED

Person responsible to bill:	DOB:	Address (if different):	Home/Cell Phone:

Is this patient covered by insurance? ☐ Yes ☐ No	Will this patient be self pay? ☐ Yes ☐ No

Name of Insurance Company:			Cardholder's Name:
Insurance ID #:	Group #:	Copay: $	Relationship to Patient:
			Cardholder's DOB: / /

Occupation:	Employer:	Employer Phone #:

Credit Card On File Agreement

Please be advised of the following terms of our Financial Policy Agreement:

Outstanding Bills: It is not my policy to carry balances with my clients. Co-Pays are due at the time of services. Unless there is a Financial Hardship Form approved and on file, I will charge co-pays each session and/or charge deductible/co-insurance after insurance has processed the claim or at month end

Missed Sessions: Any missed sessions or cancellations without a 24 hour notice will be charged to your designated credit card.

Client Name: _____

Credit Card Type: ☐ VISA ☐ MasterCard

Card Holder Name: _____

Billing Address: _____

_____

Credit Card Number: _____

Expiration Date: _____ **Security Code:** _____

I agree to the terms above and authorize Julie Hanson LCSW to bill my credit card for any unpaid balances due or for any missed appointments.

Signature: _____ **Date:** _____

Julie Hanson, LCSW

INSURANCE CHECKLIST AND VERIFICATION OF BENEFITS

Prior to your first visit, you must call the phone number on the back of your insurance card and follow these steps to identify your insurance benefits.

Patient Name: _____

Policy Holder Name: _____

Primary Insurance: _____

1. **Give the insurance representative the appropriate credentials below:**

   Julie Hanson, LCSW NPI: 1588071732 Tax ID: 47-2578036

2. Ask "What are my benefits for "in-network outpatient behavioral health?"

Amount of co-pay/co-insurance? _____
How many sessions are allowed? _____
Do I have to satisfy a deductible/how much? _____
Are there 2 separate levels of benefits? Serious & Non-Serious? _____

3. Ask "Is my therapist covered under my benefits package? If "No", "what are my out-of-network benefits?"

Amount of co-pay/co-insurance? _____
How many sessions are allowed? _____
Do I have to satisfy a deductible/how much? _____
Are there 2 separate levels of benefits? Serious & Non-Serious? _____

4. Ask "Do I need pre-authorization before I can be seen by my therapist?"

If yes what is the authorization # _____
Number of sessions approved _____
Name of rep and date of your phone call _____

4. Insurance Company claims address:

_____
_____
_____
_____

Common Procedure Codes:

90791 - Initial Appointment (55)
90837 - Individual Therapy (45)
90837 - Individual Therapy (55)
90848 - Family Therapy (45)

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZATION payment to be made directly to Julie Hanson, LCSW of any insurance benefits covering my care and treatment. I understand, as signee, I am financially responsible to Julie Hanson, LCSW for all charges that are not covered by my insurance company I also five Julie Hanson, LCSW permission to release any of my health information obtained during examinations or treatment that may be necessary to support any insurance claims. Further, by signing below, I acknowledge that Julie Hanson, LCSW is not responsible for securing authorization or coverage buy my insurance carrier for my treatment and services, and I understand that Julie Hanson, LCSW cannot be held liable for any limitation of coverage orderliness authorization by my insurance policy.

Patient Signature: _____

Parent/Guardian Signature: _____

Therapist Signature: _____

Practice Policies

Confidentiality: Under state and federal law, matters discussed with your psychotherapist are confidential unless exceptions exist under the law. In most cases, n order to release any information related to your treatment, we will require you to sign a release of information. During therapy, you may request that some information be discussed with another person (i.e. your physician, spouse/partner, children, parents, teacher/school, etc). If you desire that information be communicated about you to someone else, please ask for a release of information form. If I feel that it will be useful to you during the therapy process, to discuss your progress or situation with another person, you will be asked for your written permission to do so. Please refer to you HIPAA Notice of Privacy Practices for additional information regarding your rights as to the release, use and disclosure of your protected health information.

Cancellation Policy: If you **do not come** to your appointment or **cancel with less than a 24 hour notice**, **I will bill you $100 for that missed session**. The fee can not be submitted to your insurance company for reimbursement. As such I require all patients to keep a credit card on file that may be used in the instance an appointment is missed without the required advanced notice. Scheduling an appointment means that it will be held only for you and, therefore, cannot be used by another person. If you are late, the session will still end at the normal time.

Children in the Waiting Room: We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safely if left unattended. For the safety and welfare of the children and out of consideration for others, please make other arrangements for childcare during therapy sessions. Parents who do not comply will risk the cancellation of their designated appointment. Parents will be held responsible for any property damage caused by their child.

Fee and Payment Policy: You will be billed for all time spent with you or on your behalf including but not limited to time spent preparing reports and documents and consultation with other professionals on your behalf. Payment is requested at the time of each session either by cash, check or credit card. The initial intake fee is $175. The standard fee for a session of individual therapy ranges from $130 - 150, depending on length and technique utilized. Phone calls longer than ten minutes will be prorated by then minute increments of the regular fee. Payment is due each meeting and can be made by check or cash. Please make checks payable to **Julie Hanson, LCSW**.

Insurance: All fees are your responsibility. In order too pay with insurance, you must complete the Insurance Checklist Form. If your insurance policy does not cover the necessary services, or you do not received prior authorization as required by your insurance company, or such authorization has not been obtained in a timely manner or has been denied by your insurance carriers you agree that you will be responsible for the entire payment for services and may be billed as a private/self-pay. Further, you understand that you are responsible for and agree to pay any copayments, deductibles, co-insurance, non-covered services or amounts in excess of your health insurance policy's annual and/or lifetime maximum benefit and understand that any such payment is due at the time of service.

Please note that if you are billed as private/self-pay, this is considered out of pocket and cannot be submitted to insurance.

Appointments: Therapy sessions will typically be on a weekly or bi-weekly basis. Additional appointment times can be arranged on an "as needed basis". A "therapy hour" is typically 55 minutes in duration and may be referred to as a "clinical hour". Sessions can also be 45 minutes in duration depending on insurance/billing guidelines.

Telephone Messages: Due to the structure of my appointments I am not always able to receive "live calls". You may leave a message at 847-737-5277 x108 at any time. I will return your call promptly.

Authorization for Electronic Communication: As a convenience to me, I hereby request that Julie Hanson, LCSW communicate with me regarding my treatment by Julie Hanson, LCSW via electronic communications (e-mail or text message). I understand that this means Julie Hanson, LCSW will transmit my protected health information such as information about my appointments diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Julie Hanson, LCSW shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Julie Hanson, LCSW to me.

I agree that Julie Hanson, LCSW may communicate with me electronically unless and until I revoke this authorization by submitting notice to Julie Hanson, LCSW in writing This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

Duty to Warn: Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the psychotherapist may "warn" any intended victim, as well as the responsible authors, and disclose confidential information where a client discloses in session that he or she intends to cause serious mental or physical harm to a specifically identifiable victim and presents a clear and imminent risk of harm. It is then the psychotherapist's responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and /or the victim might prevent the harm from occurring and/or in order to prevent a serious

threat to public safety. Therefore, if a client discloses an intent to harm a specific person, the psychotherapist must either contact that person and the authorities, or attempt to secure the hospitalization of the individual. These disclosures are also protected by an immunity clause in the statute.

Mandated Reporting: The abused and Neglected Children's Reporting Act in Illinois requires that "Mandated Reporters" must disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and Family Services (DCFS). I am a mandated reported, as are all mental health service providers. The only requirement is that the "provider" has a good faith belief or conclusion that a neglect or abuse situation exists. If this is so in the mind of the mandated the law absolutely requires that a phone call be made to DCFS such that DCFS may investigate the situation. If such a report is made, it is my policy to first advise the client that the report will be made. Subsequent to a "mandated" report the client , and possibly others will be contacted by a follow up investigator from DCFS. If these investigators confirm the presence of abuse or neglect, a letter so indicating will be issued, and possible court hearings could result. If the DCFS investigators conclude that no abuse or neglect has occurred, a letter will be issued indicating that the claim is "unfounded". The mandated reporter has no choice but to make reports in these situations. The client should be aware that the statute provides for loss of license if a mandated reporter fails to make a mandated report. The statute also provides the mandated reporter with absolute immunity from any criminal or civil liability in the event that such a report is made, even without the consent of the client

Client Acknowledgement & Informed Consent: I have read and understand these policies.

Client signature: _____ **Date** _____

_____

Parent/Guardian Signature for Child*

* Signature or Parent, Guardian or Personal Representative for a child under the age of 12 years. If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Therapist Signature: _____ **Date:** _____

Julie Hanson, LCSW
CONSENT TO TREATMENT

1. I hereby consent to receiving counseling and psychotherapy from Julie Hanson, a licensed clinical social worker.
2. Knowing that my condition may require a mental health diagnosis and require treatment, I do hereby authorize and request treatment for the specific condition identified.
3. I hereby release Julie Hanson, LCSW from responsibility for any injury which results from my termination of treatment, against her advice.
4. I am seeking counseling of my own free will without coercion from any person or organization.
5. I have been informed that Julie Hanson, LCSW, is licensed by the state of Illinois to perform therapy with individuals, families or couples.
6. I have been informed that counseling is a collaborative process utilizing emotional, cognitive and behavioral processes to achieve the desired goals of treatment.
7. I have been informed that Julie Hanson, LCSW uses traditional and approved counseling techniques that will respect my values, beliefs, faith and relationships and do no intended harm.
8. Julie Hanson has informed me of the benefits and risk of therapy and I am entering therapy with full knowledge that my anxiety, depression and discomfort may increase before any relief is experienced and the desired goals may be reached with mixed results.
9. I have the right to withdraw my consent for information and agreement to treatment by informing my therapist in writing.

I have read the above statements and understand the content. I have asked questions to clarify what I do not understand.

Client signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Therapist signature: _____ Date: _____